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EU Accession: A policy window opportunity for Nursing?

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Highlights

- European enlargement has been neglected as a policy issue in nursing
- The extent to which nurse leaders used enlargement as a policy window is examined
- Case studies of Romania and Croatia were analysed for leadership engagement
- Professional leadership need to be aligned to policy goals to optimise impact
- Commission mechanisms need to be strengthened to facilitate professional engagement

Abstract

European enlargement has been studied in a wide range of policy areas within and beyond health. Yet the impact of EU enlargement upon one of the largest health professions, nursing, has been largely neglected. This paper aims to explore nurse leadership using a comparative case study method in two former Communist countries, Romania and Croatia. Specifically, it considers the extent to which engagement in the EU accession policy-making process provided a policy window for the leaders to formulate and implement a professional agenda while negotiating EU accession.

Findings of qualitative interviews and documentary analysis indicate that the mechanisms used to facilitate the accession process were not successful in achieving compliance with the education standards in the Community Acquis, as highlighted in the criteria on the mutual recognition of professional qualifications set out in Directive 2005/36/EC. EU accession capacity building and accession funds were not deployed efficiently to upgrade Romanian and Croatian nursing education towards meeting EU standards. Conflicting views on accession held by the various nursing stakeholders (nursing regulator, nursing union, governmental chief nurse and the professional association) inhibited the setting of a common policy agenda to achieve compliance with EU standards. The study findings suggest a need to critically review EU accession mechanisms and better align leadership at all governance levels.

Keywords – Community Acquis; EU accession; nursing leadership; stakeholder engagement; TAIEX; health policy

Introduction

While European enlargement has been studied in a wide range of policy areas, the impact of EU enlargement upon one of the largest health professions, nursing, has been largely neglected (De Raeve, 2011). The present study considers the extent to which engagement in the EU accession policy-making process can provide a policy window for key nursing stakeholders (the leaders of the professional organisation, the nursing union, regulator and governmental chief nurse) to formulate and implement a professional agenda while negotiating EU accession.

The European Union (EU) accession process consists of negotiations between national government and the European Commission with the aim of aligning national legislation with the *Community Acquis,* which encompasses accumulated legislation, legal acts, and court decisions constituting the body of EU law (European Commission, 2004). The Acquis comprises 35 chapters reflecting the broad sectors of EU responsibility; key among these is Chapter 3, the free movement of people and services. This chapter refers to legislation and case-law concerning the free movement of professions based on the

mutual recognition of professional qualifications, including the education of "nurses responsible for general care" (Directive 2005/36/EC[1](hereinafter: the Directive).

Compliance with the requirements outlined in the Directive 2005/36/EU is a condition for the free movement of nurses within the EU and training programs have to adapt to the requirements of the Directive for all newly trained nurses. The way in which the EU accession negotiations relate to qualifications of health professionals can be instrumental in advancing nursing as a profession. The Directive aims to ensure that nurses who want to make use of their rights to free movement are trained according to EU standards. In this way, the Directive is a tool designed to create an internal market and growth in the EU and to boost employability of a skilled workforce. The study therefore focusses on stakeholders using EU accession as a potential policy window to further their own agenda and goals in the domestic arena.

The study draws on Sedelmeier's (2011) conceptualisation of Europeanisation by including the dynamics of pre-accession and analysing how durable and distinctive the patterns of candidate EU accession countries are (Börzel & Risse, 2003; Börzel, 2005; Falkner et al., 2003; Radaelli, 2003; Cowles et al., 2001). Most scholars define Europeanisation as the 'domestic impact of Europe and the EU' in the sense that EU members and non-members adapt and change domestic institutions in response to EU rules and regulations (Börzel & Risse, 2007; Featherstone & Radaelli, 2002). Europeanisation refers to, first, the development of European level structures of governance, second, processes and mechanisms by which European level decisions and institutions influence domestic decisions and institutions, and third, the effect of the EU and other European institutions on member states (Börzel & Risse, 2007, p.484-486). With regards to candidate countries Europeanisation and the EU's attempt to influence domestic adjustment prior to accession, Sedelmeier (2011) posits that the important question is of durability of both the adjustment patterns and the EU's pre-accession influence. It is believed that reassessing some of conceptual insights as well as the analysis of the effectiveness of the mechanisms used to process enlargement, can provide new knowledge on the process of Europeanisation (Sedelmeier, 2011). In this way, this study aims to contribute to the broadening of the conceptualisation of 'Europeanisation' using nursing as an example. Examining the political mechanisms leading to the adoption of the EU Directive in relation to nursing during EU accession sheds some light on the process of Europeanisation in candidate countries. It is suggested that for new members, the period, during which adjustment changes could be designed and implemented, becomes a policy window.

This paper focusses on the compliance of national Romanian and Croatian legislation with the Directive prior to EU accession. Compliance from a nursing perspective implies transposing the minimum requirements of the Directive which relate to: the entry level of general education; a full educational programme of 4600 hours; a minimum one third of the educational programme as theoretical and minimum one half as clinical training on a full-time basis; and the curriculum including at least the study topics as described in Directive Annex 5.2.1. As the nursing profession is one of the most mobile professions in the EU (IMI, 2013), compliance with the Directive is crucial for patient safety and quality of care (De Raeve, 2011; Keighley, 2009).

The compliance policy process for EU membership is supported by the European Commission's Technical Assistance and Information Exchange (TAIEX) peer reviews and capacity building seminars. TAIEX is the instrument responsible for all technical assistance elements that prepare governments for the application of the Acquis (European Commission, 2011). These peer reviews have the main objective of determining whether adequate administrative infrastructure and capacity are in place to ensure full implementation of the Acquis. Peer review reports pinpoint areas that require further

[1] Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of Professional Qualifications, 2005 O.J L 255,30.2005, pages 22-142

strengthening. The TAIEX capacity-building seminars are therefore largely demand driven, facilitating the delivery of appropriate, tailor-made expertise to address the shortcomings identified in the TAIEX peer review reports (European Commission, 2004). The capacity building efforts aim at increasing understanding of EU legislation in beneficiary partner administrations, promoting networking amongst participants and facilitating the exchange of best practices and experiences. A second evaluation can take place to measure progress - the peer review reports tend to be an important source of information for the European Commission (hereinafter: the Commission) comprehensive monitoring reports, on the basis of which political leaders from the Commission, the European Council and the European Parliament make informed decisions on progress towards compliance with the Acquis.

The study aims to explore nurse leadership engagement with the EU accession policy-making process; and the extent to which EU accession was used as a policy window to advance a professional agenda. The challenges the study sought to address relate to the position of nurses in the policy-making process, compliance with educational standards in the EU and uniting the voice of nursing to set the political agenda that influences the government negotiated outcomes from accession.

Context: pre-EU accession

An important part of the background to the research informing this paper is how nursing leaders were socialised during the former communist regime. Prior to 1990 both Romania and Croatia were communist states, but they experienced communism differently. Romanian nursing leaders and policy-makers negotiating the *Acquis* had experienced the Ceausescu regime and perceived it as one of the harshest and most nationalistic of the communist dictatorships (Bideleux & Jeffries, 2007; Crowder, 2007; Linz & Stepan, 1996; Gallagher, 1995; Barnett, 1992); in contrast, Croatian nursing leaders and policy-makers experienced a more liberal Titoist Communism (Djilas, 2007; Živanov, 2000).

Unlike other countries in eastern and central Europe towards the end of the 20th century, Romania's political revolution was violent, ending with the execution of Nicolae and Elena Ceausescu on 25 December 1989 (Goldfarb, 2006). However, except for the ten-week military confrontation in 1999 between NATO and Serbia, Romanian nursing leaders and policy-makers were not exposed to the Balkan war (1991-1996). In contrast, Croatian nursing leaders and policy-makers experienced the consequences of the ethnic Balkan War directly (Voncina et al., 2006), which impacted on the trust the nursing leadership had in the system to develop policies.

Both countries moved from a totalitarian regime to democracy. The political transition in the early 1990s led to a mass of health system decrees and regulations in both Romania and Croatia (Gaal & McKee, 2004; Rechel et al., 2004; Ho & Ali-Zade, 2001; Busse & Dolea, 2001). Despite reforms passed by their respective parliaments, there have been ongoing problems with implementing change in practice. This is especially true for the nursing profession and is due, in part, to the lack of a clear strategy and objectives (Busse & Dolea, 2001). Romania and Croatia both share the legacy of a Soviet-influenced health-care system, based on the hospital-focused Soviet Semashko model with the continuing use of informal payments (Gaal & McKee, 2004; Rechel et al., 2004; Ho & Ali-Zade, 2001). Within this model the nursing profession in both countries has suffered because of attitudes and mind sets persisting from the post-communist conservative regime. Such legacy left leaders struggling to upgrade the quality of nursing education.

Although the context of both countries differed, both Romania and Croatia faced similar challenges in 1) adapting national policy structures to meet the *Acquis* criteria, 2) implementing minimum EU standards on the content and duration of nursing education and 3) moving nursing education from a secondary level to a higher or university level of professional qualifications. However, it is likely that

due to the different political context, they differed in their perceptions of EU agenda-setting and in the political will to implement EU nursing legislation.

Materials and methods

This comparative case study of two countries, Romania and Croatia, followed an ethnographic approach. It focussed on the mechanisms used by the Commission to process compliance and the degree to which nursing leadership capitalised upon the opportunity to formulate and implement a professional agenda and to achieve policy goals in Romania and Croatia.

The main criteria for selecting Romania and Croatia relate to: their historical and political contexts; their different positions within the EU accession process – especially timing and the stage reached in the overall accession process at the time of the study (2005-2013); and, the different levels of development of the nursing profession.

The study adopted a qualitative ethnographic approach, involving semi-structured interviews and documentary analysis. The ethnographic aspect in the method relates to the cultural context and its impact upon the mind sets, attitudes and behaviours of leaders captured through semi-structured interviews. A purposive and snowball sampling approach was used to recruit 30 policy makers drawn from different backgrounds, including nurses and decision makers associated with EU accession.

An initial set of interviews in Romania were undertaken in 2006 followed up by a second sequence in April 2010, three years after Romania had joined the EU. In Croatia, only one set of interviews were collected in 2007, since Croatia's accession was delayed (until 2013) owing to failure to co-operate fully with the war crimes tribunal in The Hague. In total, 30 participants were recruited; 15 in each country. Initially, a total of 11 interviewees were recruited through purposive sampling; followed by recruiting another 19 interviewees through networking and snowballing approaches until theoretical saturation was achieved.

Documentary analysis focussed on EU accession primary source reports; specifically, the annual Commission comprehensive monitoring reports and the TAIEX Peer Review reports from 2004 for Romania and 2008 for Croatia. The latter documents reflect the progress made during the accession negotiations and challenges, which needed to be addressed by the Romanian and Croatian governments prior to accession agreement. Furthermore, unpublished reports from governmental and nongovernmental organisations were important sources of information on the political processes and dynamics underpinning accession. These documents were read paying attention to issues considered and omitted; how solutions were framed; whose voice was present and absent; and the power relationships that appeared to exist between the subjects of the reports, the writers and the commissioners. These qualitative data provided a yardstick against which to measure the comprehensiveness of and meaning given to the data gathered from the 30 interviews.

The study adopted an iterative-inductive-reflexive approach to analysis (Maxwell, 2005) aiming at identifying constructs, themes and patterns to better understand and explain nurse leadership engagement with the EU accession policy-making process. Themes, concepts and patterns emerged out of the interviews rather than being imposed on the data prior to data collection and analysis. Consistent with the adoption of a comparative case-study method, each case was first regarded individually. At a later stage, themes and concepts were considered across both cases to equilibrate the comparative nature of the research objectives. The starting-point for the inductive analysis was coding the interview transcripts by attributing a label to sections of raw data linked to the identified concept; assigning a meaning to the label as echoed by the interviewee; and searching for enlarging and refining understanding of existing and emerging concepts and themes as more transcripts were added to the analysis. NVivo was used for manual coding of all transcripts and attributing text

references to emerging concepts. The coding process was reflexive and ensured that the themes and concepts identified were consistent with the participants' views and meanings throughout the analysis.

Ethical considerations related to interviewing political elites, the need to use interpreters for some of these interviews and the need to guarantee participants' confidentiality. Ethical approval was sought and obtained from the King's College London Research Ethics Committee in February 2006 (reference 05/06-61).

Results

Results are presented on the robustness of the EU compliance mechanisms and how the nursing leadership was able to engage in agenda setting and policy-making. With regard to the former; three policy mechanisms were identified, which were used to reach compliance with the *Acquis*: 1) the Commission's Comprehensive Monitoring Reports, 2) the TAIEX peer review reports, and 3) the TAIEX capacity-building seminars. Findings suggested that these three policy mechanisms were not robust enough to deliver successful legislative change, however, comparison of the Romanian and Croatian cases showed that the TAIEX peer reviews and capacity-building seminars enabled the nursing leadership to influence the process and advance nursing as a profession in a medically-dominated policy and clinical environment. But the TAIEX peer review recommendations and capacity building generated knowledge were helpful to keep up the political momentum but the recommendations were only partially integrated into the Commission's Comprehensive Monitoring Reports discussed within the European Institutions. As such, the study concluded that the compliance mechanisms did not have sufficient traction to move from legislative endorsement to legislative implementation through governmental commitment and stakeholder engagement.

Commission Comprehensive Monitoring Reports

The annual Commission Comprehensive Monitoring Reports are an important tool for enabling European political leaders in the Council and European Parliament to evaluate the progress made by the applicant for EU accession. Comparing documentary evidence from two countries, which were the focus of earlier TAIEX missions, allows us to see how decision makers from the EU make certain judgements on their compliance process. In Romania, one sentence in the Comprehensive Monitoring Report of 2002 stated that "no progress was made on mutual recognition for the sectoral professions". Such an implication is intended to make the Romanian government aware of non-compliance with the Directive. Consequently, halfway through the EU accession process (June 2004) the European institutions agreed to create a safeguarding clause for Romania as the 2002 and 2004 TAIEX peer review reports provided evidence of key areas that required further strengthening to achieve full compliance. This increased the political pressure by delaying entry to the EU by one year if the Romanian government failed to meet its political and economic targets.

Furthermore, the Comprehensive Monitoring Report of 2004 stated that, although Romania had achieved stability of institutions guaranteeing democracy and the rule of law, public administration "is still characterised by cumbersome procedures, a lack of professionalism, inadequate remuneration and poor management of human resources". However, two months after the European political leaders agreed the Comprehensive Monitoring Report of 2004 all chapters of the Acquis became provisionally closed – implying that Chapter 3 and the Directive were being transposed into national legislation. The Comprehensive Monitoring Report in September 2006 concluded that: "Romania will be in a position to take on the rights and obligations of EU membership on 1 January 2007" (European Commission, 2006). But it was only in 2013 that the European Parliament and the European Commission forced the Romanian government to introduce bridging courses for nurses to remove the derogation as foreseen in the Directive (European Commission, 2013). Thus, even though this

requirement has been set the government persisted in dragging its feet. The deadline for achieving this goal is January 2018.

In Croatia, over a five-year period of Commission reporting on the progress of EU accession, reference was made to the lack of harmonisation of the rules concerning regulated professions to ensure the mutual recognition of qualifications and diplomas between Member States. The 2005 report refers to the Croatian government setting up a centre for academic mobility and recognition of higher education qualifications within the Agency for Science and Higher Education. This appears to cover mainly academic recognition, with limited impact on the recognition of professional qualifications. In 2006 and 2007, the Commission Monitoring Reports to the Council and European Parliament stated that no progress could be observed regarding the mutual recognition of professional qualifications.

Croatian legislation did not distinguish between the recognition of academic and professional qualifications, suggesting the Directive was not followed through. The 2008 Commission report highlights that the minimum training requirements for all medical professionals – doctors, dentists, midwives, nurses, pharmacists – were still not in line with the Acquis. The 2009 Commission monitoring report mentioned some progress on the mutual recognition of professional qualifications and so Chapter 3 of the *Acquis* was provisionally closed on 21 December 2009. All *Acquis* chapters were provisionally closed in December 2010, despite the knowledge that a second peer review was needed to measure progress (European Commission, 2012). The Croatian Government signed the Accession Treaty in 2011 implying that the Commission had agreed that the Directive, as part of Chapter 3 of the *Acquis*, had been transposed into a new Croatian Nursing Act.

TAIEX Peer Review Reports

Both the Romanian and Croatian cases showed that although the TAIEX peer reviews emphasised prominent areas that required further attention, their recommendations were not an important source of information for the Commission's Comprehensive Monitoring Reports on which EU political leaders make informed decisions on compliance. Chapter 3 of the Acquis was provisionally closed although there was no evidence of the TAIEX recommendations being addressed adequately.

Rather findings from the interviews indicate that the TAIEX peer review reports were treated as a negotiation tool between the government and the Commission, with only minor engagement of stakeholders, in particular the nursing leadership, to formulate solutions to address the TAIEX recommendations. The nursing education weaknesses identified in the TAIEX peer review reports were not addressed due to governments' lack of preparedness to upgrading the Romanian and Croatian nursing workforces towards EU standards. While the TAIEX recommendations could have a political impact on negotiations, the governments' reluctance to admit they were lagging behind EU standards for nursing education impacted negatively on the development of the nursing profession in Romania and Croatia.

Interviews also demonstrated that the government negotiators and the nursing leadership held divergent views with regards the need to transpose the Directive's minimum requirements into national legislation and curricula. The newly designed nursing curricula still contained general education topics (e.g. language, mathematics) but remained very medically-orientation with physicians teaching nursing. Clinical placements hours and the implementation of the new roles of nurses as responsible for the planning, delivery and evaluation of nursing care also remained major challenges for achieving compliance with the Directive. Consequently, nurses in Romania and Croatia were still called medical assistants and therefore faced problems accessing free movement in the EU (Maciejewski, 2012). These challenges have remained unresolved as the Romanian and Croatian national governments saw the *Acquis* as a potential exit route for nurses lured by better working conditions in other EU Member States. Both governments agreed with the Commission that they

would install a new programme of nursing education at university level in compliance with the Directive, from the date of entering the EU. This left the nursing workforce trained in pre-accession years in non-compliance.

Finally, the TAIEX peer review recommendations touched on the division of accountability and responsibility between the nursing regulator, trade union, professional nursing organisation and the governmental chief nurse at the ministry of health. According the interviewees, these remain unresolved issues causing confusion and conflicts, while designing new policies allowing for a clearer task division could have been an opportunity to address these challenges. Importantly, the findings suggest that contextual conditions required a united nursing leadership capable of consensus building between the different leaders who were driving policy outcomes.

TAIEX Capacity Building sessions

A further mechanism was the TAIEX capacity building seminars aimed at addressing the weaknesses highlighted in the peer review reports. Assistance was given through expert missions, workshops or seminars and study visits. The main target groups were civil servants working in public administrations at national level, the judiciary and law enforcement authorities, parliaments and civil servants working in parliaments and legislative councils, professional and commercial associations as well as representatives of trade unions and employers' associations. All these groups can take part in TAIEX seminars led by nursing leaders, mainly from the professional association, being concerned about compliance with EU standards. The TAIEX capacity building seminars were designed to facilitate a better understanding on how to translate the Directive into national legislation, and how to address the challenges highlighted in the TAIEX peer review reports. Nurses were included in these seminars through their professional association, the union or the regulatory body.

In contrast to Romania, the Croatian findings showed that the TAIEX peer reviews were focused on evaluation of legislative and administrative capacity. The Directive helped in the design of a roadmap for future technical assistance by allocating EU accession funds to address some of the key identified challenges. The Croatian professional association organised three TAIEX capacity building seminars with the ultimate aim of bringing together nursing stakeholders and building consensus across the nursing constituency with policy-makers (mainly physicians and lawyers) who were involved in negotiating the Acquis. The Croatian case provides empirical evidence of the positive impact that capacity building mechanisms can exert on the engagement of state and non-state stakeholders across multiple levels of government. In this case funds for nursing were requested from the EU to build capacity for alignment with EU Directive standards. But in doing so the government admitted that there was a problem to be fixed. Since only the government can apply for EU capacity-building funds, the Croatian government supported the nursing leadership in organising four capacity building seminars. At the same time the Romanian government did not see the need to address shortcomings. Findings indicate that the Romanian government was slow to act and to concede the size of the compliance challenge. It was therefore likely to overestimate the degree of alignment between the existing provision and what a reformed package of legislative measures necessary for developing nursing education might look like. Failure to demand EU support appears to have been a major missed opportunity to bring together relevant stakeholders to design new national nursing legislation in compliance with the European Directive.

Nurse leadership engagement with EU accession

Nursing leadership engagement with EU accession relied on the behaviour and skills developed and acquired during the pre-democratic regime. This created little possibility for the nursing leadership to influence the Comprehensive Monitoring Reports. They did not use the opportunity to apply for EU funds for capacity-building seminars in order to address the weaknesses set out in the TAIEX peer

reviews. There was no precedent for this kind of policy intervention, suggesting that the leadership's inability to craft a unified and coordinated position has significantly reduced the nursing profession's overall capacity to influence the policy process and associated with it legislative and professional outcomes In contrast, the conflicting agendas between nursing leaders left politicians pursue their own priorities with responsibility to accept the situation where the legislative and professional outcomes remained in the hands of civil servants, mainly physicians and lawyers. Such failure was a consequence of weak ties between nursing organisations, their limited track records of operating in the EU accession policy environment. It was also due the poor political leadership of the nurse leaders in formulating clear joined-up agendas for developing the nursing education in line with the Directive while the policy window of EU accession was open.

With respect to professional outcomes, the divergent interests and powers of the nursing leadership seems to have inhibited leaders from seizing EU accession as an opportunity to move nursing away from a sanitary vision and improve working conditions in the medically-dominated Soviet Semashko model of healthcare in both countries. The nursing leadership needed to influence its own community in order to move the nursing forward. This proved to be a major challenge for the leaders who were jointly addressing the key professional and regulatory concerns as well as gaps in national legislation identified in the TAIEX peer review recommendations. In both Romania and Croatia, regardless of the position of each nursing leader, it appeared to be impossible to speak with one voice for nurses and nursing at the time.

EU accession did not appear to provide the opportunity to clarify and designate the boundaries of accountability and responsibility between the nursing regulator, trade union, professional nursing organisation and the governmental chief nurse at the ministry of health. This led to confusion about their roles in political process, with major conflicts between these four nursing leaders in each country. The diverging views and interests of the nursing leadership concerning the development of nursing education and the profession meant that compliance negotiations were left mainly in the hands of vested interests. These predominated over stakeholder engagement and excluded non-state stakeholders (civil society) from the EU accession policy process.

The Romanian and Croatian nursing leadership indicated that the rivalry between the respective ministries of education and of health created new agencies, governmental departments and committees which fragmented the mutual recognition process. The rivalry over responsibility for the recognition of credentials between the ministries reflected the tensions within the nursing community. The nursing regulator, professional association, nursing union and the governmental chief nurse were each trying to maintain their own influence and control over the recognition of professional qualifications and thereby constraining the future professional development of the nursing profession.

Discussion

Findings indicate that although Communism had ceased to prevail politically for many years, its cultural legacy persisted. Specifically, nurse leaders brought up during Communism, some of whom were party members prior to 1990, appeared to prefer to keep nursing at sanitary and secondary level. At the same time, there was a new strand of opinion supporting the development of nursing as a profession by implementing the Directive, however these views were silenced by many tensions.

Based on these findings, it can be argued that compliance with Directive 2005/36/EC was not a major concern of the Romanian and Croatian government; it was clear that the Commission's comprehensive monitoring reports were ineffective in using EU accession negotiations to upgrade nursing education. The case study findings show that the Commission mechanism (the comprehensive monitoring reports) failed to ensure that recommendations for compliance were carried through to alignment with legislative change were not enforced when closing chapters of the Acquis. As such it can be argued

that the Commission's comprehensive monitoring reports were not designed for multi-level governance (Bruszt, 2008), through which important influence at international and European level is brought to bear upon a national political agenda-setting process. As Europeanisation is a policy process in which authority and policy-making influences are shared across multiple levels of government - subnational, national and supranational (Marks & Hooghe, 2001) – it can be argued that the mechanisms for reaching compliance were not sufficiently robust to respond to the nursing education challenges that needed to be addressed prior EU accession. Grabbe (2006) indicates that costly reforms, such as education or health and safety, are often postponed while areas expected to have high benefits, privatisation and competition, are given higher priority. Whereas health is increasingly seen as an important indicator for economic growth (European Commission, 2011; Greer, 2005), liberalisation and free movement based on the mutual recognition of professional qualifications remain a challenge as far as the nursing profession is concerned.

The study, therefore, serves as a litmus test of the effectiveness of the mechanisms that the EU used to 'Europeanise' these countries prior to accession. Pre-accession conditionality was a requirement for the new member countries from Central and Eastern Europe and the study demonstrates that Europeanisation call does not result in changes necessary for the transferability of nursing professional qualification in pre-accession period. In these two cases adjustment mechanisms were neither robust nor durable and Europeanisation as far as nursing profession is concerned is dependent on a longer period of integration. Specifically, the accession window was not used to achieve compliance with the Directive due to several blockages at the domestic level.

It can be argued that the power differentials and rivalry between the ministries and different types of leadership on the national level weakened the nursing advocacy efforts. The study, therefore, helps to explain why nursing leadership in Romania and Croatia were unable to capitalise upon the EU accession policy window. The absence of an effective stakeholder engagement approach to set the political agenda, and design new policies in accordance with the *Acquis*, led to a lower level of acceptance for the legislative policy design. This inhibited professional development according to European standards. Based on the case study findings, it can be argued that EU accession was not a destination but rather a starting point for empowering the nursing leadership advocacy work in Eastern European countries. Thus, EU accession became a missed opportunity for nurses to develop their skills and competencies and hence promote their ability to move within the EU on the basis of mutual recognition of professional qualifications.

Findings support Avdagic's (2001) views that the Commission comprehensive monitoring reports did not provide a critical assessment regarding the implementation of the EU accession requirements and that EU accession was handled almost exclusively by the governments, with the *Acquis* being declared confidential. However, these forms of political reporting towards the EU institutions are clearly crucial in outlining a common strategy concerning the implementation of EU law into national legislation (Borbély, 2001). The European Council and European Parliament needed to make informed political decisions based on robust mechanisms to assess progress on compliance and on an effective stakeholder engagement when a national government and the European Commission negotiate. Furthermore, it can be concluded that the policy outcomes were determined by the weak TAIEX mechanisms – mainly due to the lack of enforcement of the peer reviews and to the fact that capacity building sessions not being advocated for or applied for. In addition, the Commission comprehensive monitoring reports lacked the political clout to put EU accession on hold till all weaknesses noted in the TAIEX reports had been addressed. Lack of alignment between the Commission's comprehensive monitoring reports and the TAIEX peer review reports clearly questions function and impact of the latter on country-specific agenda setting legalised by EU institutions.

Although these mechanisms can be construed as a barrier to effective compliance, the leadership capacity of the nursing community (e.g. professional association, nursing regulator, nursing union,

chief nursing officer) also needed to be addressed. Findings indicate that the lack of a united voice in agenda-setting (Underdal, 2012) undermined attempts to set, let alone to achieve, policy goals. Nursing leadership bodies must simultaneously strengthen different leadership positions (governmental chief nurse and those within nursing regulator, nursing union and professional association) as well as enabling a more collective and dispersed model of leadership to flourish. Thus, leadership becomes a process whereby an individual nurse leader advocates and influences a group of policy-makers and politicians to achieve the common goal – compliance with Directive. Although Porter-O'Grady's (2003) defines nursing leadership as a multifaceted process (e.g. identifying goals, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals), the findings show that individual interest is a key driver of leadership. Findings reflect Bonney's (2003) conclusion that those interested in policy-making focus on those mechanisms designed for individuals rather than collective groups, with the risk of preserving "the status quo rather than producing major change". Individual leadership differences can explain substantial variance in policy outcomes. In the two cases studied, nursing leadership remained imbued by the culture of the Communist regime in which nurse leaders' interests, their patterns of interactions and conflicting roles in policy design set the level of compliance with the Directive.

Conclusions

Based on the study findings, it can be concluded that EU accession was not a destination but rather a starting point for Romanian and Croatian nursing education to comply with European standards as set out in the Directive. The failure of the nursing leadership to achieve successful legislative and professional outcomes at national level in compliance with EU nursing education standards relates to (i) the inherited policy and political context of the former Communist regime; (ii) the weakness of the Commission's mechanism to achieve compliance; and, (iii) the lack of unity within the nursing leadership community - professional association, nursing regulator, nursing union, chief nurse - in setting a joint professional agenda and, equally, engaging with EU accession.

The mechanisms needed to process compliance, i.e. the comprehensive monitoring and TAIEX peer reviews, lacked the political power to hold back EU membership when targets were not met. Instead, the TAIEX capacity building seminars have been a tool to build the capacity of the nursing leadership to design advocacy strategies in order to address the critical gaps. The nursing leadership acknowledged that moving TAIEX recommendations up the political agenda made them reliant on the goodwill of civil servants negotiating EU accession and taking the TAIEX peer review recommendations seriously.

The Romanian and Croatian findings indicated that the TAIEX peer review recommendations were not picked up by the Commission's Comprehensive Monitoring Reports so as to enable the European Council and European Parliament to make informed decisions about Romania's and Croatia's readiness to join the EU. Equally, the nursing leadership lacked a political strategy, planning and advocacy requisites to advance the TAIEX recommendations on the national political agendas of other EU Member States agreeing the accession of Romania and Croatia. In this context, the nursing regulators and chief nurses of the EU Member States could have shared the TAIEX recommendations with their peers but appeared not to have done so. The lack of transparency hindered the development of the nursing profession in candidate countries. It is therefore concluded that the Commission's comprehensive monitoring reports lacked the power to move from legislative endorsement to legislative implementation through governmental commitment.

Finally, EU accession was handled almost exclusively by the governments. TAIEX – led by the European Commission's Directorate General for Enlargement – lacked the authority as non-state stakeholders, including European organisations to mount a challenge. It was not in a position to hold the Commission and national governments to account for failing to take concrete measures to address the weaknesses

identified during the peer reviews which benchmarked national nursing legislation with the Directive. Furthermore, moving the compliance process onto a capacity building footing would have slowed the process overall, jeopardised the EU accession and even raised questions about compliance in other areas of the *Acquis*. Instead, the ministries dealing with EU accession simply did not invest their efforts in upgrading the nursing workforce. Indeed, there was a deliberate intention to block free movement in order to counteract the danger that the nursing workforce would be lost under the free movement opportunities created by the Directive. In turn, this would have reduced the grip of national governments managing their health workforce.

Based on the evaluation of the use of Commission mechanisms to process compliance, the case study findings provide evidence that the Croatian nursing leadership was more politically oriented and adept at strengthening its advocacy capacity, it was able to exert political pressure on the EU accession process. Conversely, the Romanian nursing leadership was only mobilised post EU accession. Interpretation of the comparative findings shows that the EU accession process created a (missed) policy window for the nursing leadership to advance a professional agenda both before and after accession. Equally important, EU accession provided a mechanism for engagement in policy-making and thereby had potential to increase nurses' political knowledge, skills and advocacy capacity to steer ongoing development of the nursing profession in both of these eastern European countries.

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